Medical Benefits at a Glance

Plan Benefits/Coverage		Active Option	Family Option		Independent Option	
			Adult	Child (Dependent to Age 26)	In-Network	Out-of-Network [1]
Individual Deductible		$100 Individual $200 Family	$100 Individual $200 Family		$100 Individual $200 Family	$500 Individual $1,000 Family
Annual Out-of-Pocket Maximum		$6,350 Individual $12,700 Family max	$6,350 Individual $12,700 Family max		$6,350 Individual $12,700 Family max	$12,700 Individual $25,400 Family max
Preventive Care [2]		$0	$0	$0	$0	40%
Primary Care Provider Visit		$35	$40	$10	$40	40%
Specialist Provider Visit		$50	$55	$40	$55	40%
Behavioral Health Provider Visit		$35	$40	$10	$40	40%
Chiropractic and Acupuncture Each limited to 20 visits per plan year		$50	$55	$40	$55	40%
Outpatient Speech, Physical, and Occupational Therapy Up to 24 visits per year combined		$50	$55	$40	$55	40%
Diagnostic Lab and X-Ray		$0	$0	$0	$0	40%
Imaging and Scanning [3,4]		$125 PET/MRI $75 CT scan	$200 PET/MRI $125 CT scan	$100 PET/MRI $75 CT scan	$125 PET/MRI $75 CT scan	40%
Urgent Care [4]		$35 in network $50 out network	$40 in network $50 out network	$10 in network $30 out network	$45	$55
Emergency Room Visit [4]		$150 includes all services and waived if admitted				
Emergency Medical Transportation [4]		$50 ground/$100 air				
Hospital Inpatient Stay [3,4] Hospice/Skilled Nursing Care [3,4]		$500 per admission	$500 per admission	$350 per admission	$500 per admission	40%
Outpatient Surgery [3,4]		20% up to $500 per visit	20% up to $500 per visit	20% up to $200 per visit	20% up to $500 per visit	40%
Maternity Care – Prenatal and Postnatal		$35 per visit up to $200	$40 per visit up to $300 [5]		$40 per visit up to $300 [5]	40%
Infertility Services [4]		50%				Not Covered
Durable Medical Equipment [3,4]		50%				
Home Healthcare		$0				40%
Prescription Drugs						
Retail 30 days	Generic (Preferred)	$10	$10		$10	Not Covered
	Brand (Preferred)	$35	$30		$30	
	Brand (Non-Preferred)	$55	$50		$50	
	Specialty Pharmaceuticals	20% up to $400 per medication				
Mail 90 days	Generic (Preferred)	$20	$20		$20	Not Covered
	Brand (Preferred)	$87.50	$75		$75	
	Brand (Non-Preferred)	$165	$150		$150	
Unique Service Reimbursement		$150 per year	$0 per year		$250 per year	

[1] Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.
[2] For a complete list of preventive services, visit www.healthcare.gov/what-are-my-preventive-care-benefits.
[3] Prior authorization required.
[4] Subject to annual deductible.
[5] Per pregnancy. Delivery subject to inpatient cost sharing and prior authorization.

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